U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

Issue Date: 28 January 2005

In the Matter of:

MARY JOHNSON, o/b/o
JOHN HENRY JOHNSON, deceased,
Claimant,

Case No.: 2004-BLA-5

v.

CONSOLIDATION COAL CO.,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

APPEARANCES: Andrew Delph,
For the Claimant

Douglas Smoot,
For the Employer

BEFORE: Thomas M. Burke
Associate Chief Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This claim arises from a claim for benefits filed under the "Black Lung Benefits Act," Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, at 30 U.S.C. § 901 *et seq*. ("Act"). A hearing was held on August 31, 2004 in Abingdon, Virginia. John Henry Johnson, Claimant, filed the claim on December 10, 1979. *Dx. 1.*[1] Thus, this claim is governed by the interim regulations found at 20 C.F.R. Part 727.

[1] The following abbreviations are used for reference within this opinion: *Dx.* Director's Exhibit, *Ex.* Employer's Exhibit, and *Tr.* Hearing Transcript.

Overview of the Black Lung Benefits Program

The Black Lung Benefits Act is designed to compensate those miners who have acquired pneumoconiosis, commonly referred to as "black lung disease," while working in the Nation's coal mines. Those miners who have worked in or around mines and have inhaled coal mine dusts over a period to time, may contract black lung disease. This disease may eventually render the miner totally disabled or contribute to his death.

Procedural History

This claim is before the Office of Administrative Law Judges for the sixth time. Since the claim was filed on December 10, 1979, the Board has reviewed the claim five times, and the United States Court of Appeals for the Fourth Circuit has reviewed the claim once. Throughout the twenty five year history of this claim, Claimant has not been awarded federal black lung benefits.[2]

ALJ Kichuk was the last administrative law judge to issue a decision in this claim. *Dx. 142.* On January 6, 2000, the Board affirmed ALJ Kichuk's denial of benefits. *Dx. 147.* On January 22, 2000, Claimant motioned for reconsideration. *Dx. 148.* The Board denied the motion. *Dx. 150.*

Claimant submitted additional medical evidence and asked for modification on April 9, 2001. *Dx. 151.* The Department issued a Proposed Decision and Order Denying Request for Modification on October 1, 2001. *Dx. 163.* Claimant disagreed with the Proposed Decision and Order and asked for the claim to be forwarded to the Office of Administrative Law Judges. *Dx. 164.* On May 24, 2002, the Department issued a Proposed Decision and Order Denying Request for Modification. *Dx. 179.*

Mr. Johnson died on December 28, 2001. Mrs. Johnson, however, requested modification on May 19, 2003, claiming that "the last information we supplied from Dr. Randy Forehand and other information previously submitted was not given full consideration." *Dx. 188.* The claim was forwarded to the Office of Administrative Law Judges on September 25, 2003. *Dx. 190.* A hearing was held in Abingdon, Virginia on August 31, 2004.

The Standard for Entitlement

The interim regulations found at 20 C.F.R. Part 727 require employers to pay benefits to a miner who is totally disabled due to pneumoconiosis, was totally disabled by pneumoconiosis at the time of death, or whose death was due to pneumoconiosis arising out of coal mine employment.[3] 20 C.F.R. § 727.203(a); *Mullins Coal Co. v. Director, OWCP,* 484 U.S. 135, 139

---

[2] Administrative Law Judge Clement Kichuk's December 9, 1998 Decision and Order on Remand details the procedural history of this claim. *Dx. 142.*

[3] Although Mr. Johnson died and Mrs. Johnson is pursuing the claim on behalf of her husband, this is not a survivor's claim. Therefore, the cause of Mr. Johnson's death is not at issue.

(1987). The Claimant may invoke the presumption of total disability due to pneumoconiosis by establishing that he worked for more than ten years in the mines, and either: (1) chest x-rays establish the presence of pneumoconiosis, (2) ventilatory studies show the existence of a respiratory ailment of specified severity, (3) blood gas studies show an impairment of specified severity, or (4) well-reasoned, well-documented medical reports support a finding of a totally disabling respiratory impairment.[4] 20 C.F.R. § 727.203(a). The Claimant bears the burden of establishing at least one of the criteria by a preponderance of the evidence to invoke the interim presumption at 20 C.F.R. § 727.203(a). *Mullins Coal Co. v. Director, OWCP,* 484 U.S. 135 (1987). If benefits cannot be awarded pursuant to the interim presumption at § 727.203(a), the claim must be considered under 20 C.F.R. Part 410 Subpart D. *Muncy v. Wolfe Creek Collieries Coal Co., Inc.* 3 B.L.R. 1-627, 1-634 (1981).

Issues Presented for Adjudication

The parties stipulate to 42 years of coal mine employment. *Tr. at 8 and 9.*[5] Claimant's last job was as a section foreman, which required him to "set timbers and carr[y] canvas and drug (sic) canvas and pump." *Dx. 45 (Tr. at 16).* Claimant has established that he worked for more than ten years.

As Mrs. Johnson alleged that "the last information we supplied from Dr. Randy Forehand and other information previously submitted was not given full consideration," Claimant is alleging a mistake in a determination of fact. 20 C.F.R. § 725.310(a). This request for modification requires a de novo review of the record to determine if the evidence submitted by the Claimant was given due consideration in determining whether Claimant is entitled to benefits. *Cooper v. Director, OWCP,* 11 B.L.R. 1-95 (1988); *Kovac v. BCNR Mining Corp.,* 14 B.L.R. 1-156 (1990), *aff'd on recon.,* 16 B.L.R. 1-71 (1992). If the evidence is insufficient to invoke the § 727.203(a) interim presumption, the claim shall be considered under the regulations at 20 C.F.R. Part 410 Subpart D.

The §727.203(a) Interim Presumption

X-ray evidence

One way Claimant can invoke the interim presumption is through chest x-ray evidence that establishes the presence of pneumoconiosis. 20 C.F.R. §727.203(a)(1). The chest roentgenogram evidence of record is detailed in Appendix A. For each of the 56 interpretations of the fourteen x-ray films, Appendix A lists the date of the x-ray film, the physician interpreting the film, the qualifications of the physician, and the interpretation of the x-ray film.[6] Only 12 of the 56 interpretations are positive for pneumoconiosis, while the remaining 44 interpretations are

[4] There is a fifth alternative in the case of a deceased miner, but it only applies if there is no medical evidence. In this case, there is ample medical evidence; thus 20 C.F.R. § 727.203(a)(5) is inapplicable.

[5] This citation refers to the transcript of the hearing held before the undersigned on August 31, 2004.

[6] The results of the February 4, 2000 CT Scan are also listed. None of the three physicians who reviewed the CT Scan found evidence of pneumoconiosis.

negative. Additionally, the majority of B-readers interpreted the x-rays as negative for pneumoconiosis,[7] and the most recent x-ray, which was taken on February 8, 2001, was read as negative by a majority of the readers.

While the majority of the eleven interpretations of the February 21, 1983 x-ray are positive for pneumoconiosis, Claimant's burden is not sustained by establishing that only one of the fourteen x-ray films supports the finding of pneumoconiosis. The Claimant bears the burden of establishing pneumoconiosis by a preponderance of the evidence to invoke the presumption at 20 C.F.R. § 727.203(a)(1). *Mullins Coal Co. v. Director, OWCP,* 484 U.S. 135 (1987).

Considering the x-ray evidence as a whole, the preponderance of the evidence does not invoke the presumption at 20 C.F.R. § 727.203(a).

Pulmonary Function Studies

Claimant may also invoke the interim presumption with pulmonary function study evidence that establishes the presence of a chronic respiratory or pulmonary disease. 20 C.F.R. § 727.203(a)(2). If the studies reveal FEV1 and MVV values equal to or less than those listed at 20 C.F.R. § 727.203(a)(2), Claimant may invoke the interim presumption. The ventilatory studies must meet quality standards, which require that the test results shall be accompanied by three tracings of each test performed. 20 C.F.R § 410.430. If these quality standards are not met, the evidence will not be sufficient to invoke the presumption at § 727.203(a). 20 C.F.R. § 727.206(a).

The preponderance of the pulmonary function study evidence does not establish the presence of a chronic respiratory or pulmonary disease. Fifteen data sets from nine studies over a twenty year period are in the record. Six of the studies reveal non-qualifying values. Three of the studies that reveal qualifying values do not comply with the quality standards; therefore these studies cannot be used in invoke the interim presumption. 20 C.F.R. § 727.206(a). Two additional studies do not report the MVV value post-bronchodilator; thus, these studies cannot invoke the presumption at 20 C.F.R. § 727.203(a)(2).

On April 28, 1980, Dr. Dino administered the first ventilatory study in the record. *Dx. 10.* At the time, Claimant was 59 years old and measured 71 inches in height. Claimant's FEV1 value was 2.15. *Dx. 10.* Claimant's MVV value was measured at 38. Both values, as in this instance, must be qualifying for the study to establish the presence of a chronic respiratory or pulmonary disease.[8] This study, however, is not sufficient to invoke the § 727.203(a) presumption because the record does not contain tracings of the MVV test. The quality

[7] A "B-reader" (B) is a physician, but not necessarily a radiologist, who successfully completed an examination in interpreting x-ray studies conducted by, or on behalf of, the Appalachian Laboratory for Occupational Safety and Health (ALOSH). A designation of "Board-certified radiologist" (BCR) denotes a physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology or the American Osteopathic Association.

[8] A "qualifying" pulmonary function study or blood gas study yields values that are equal to or less than the appropriate values listed in the tables at 20 C.F.R. §§ 727.203(a)(2) and (a)(3), respectively. A "non-qualifying" study exceeds those values.

standards require three tracings of each test. 20 C.F.R. §§ 410.430 and 727.206(a). Thus, the April 28, 1980 study does not support the invocation of the interim presumption.

On July 12, 1980, Dr. Dominic Gaziano found the April 28, 1980 study unacceptable because of less than optimal effort by the Claimant. *Dx. 12.* Dr. Gaziano provides no explanation as to why he felt Claimant exerted less than optimal effort. Dr. Dino noted Claimant's cooperation and comprehension as good. *Dx. 10.* It is unclear from the record if Dr. Gaziano witnessed Claimant complete the test. Dr. Gaziano provides no reasoning for his remarks. Dr. Dino, who administered the test, found Claimant's cooperation to be good, Dr. Dino's conclusion is more likely to accurately reflect Claimant's performance in this study. Thus, little weight is given to Dr. Gaziano's comment.

On September 9, 1983, Dr. Taylor administered another ventilatory study. *Dx. 11.* Claimant was 62 years old at the time of the study and was measured 71 inches in height. The FEV1 value was 2.8. The MVV value was 87. The FEV1 value is non-qualifying while the MVV value is qualifying. This study does not support the invocation of the interim presumption.

On January 9, 1984, Claimant underwent a pulmonary function test at St. Francis Hospital. Claimant was 63 years old at the time of the study and was measured 70 inches in height. *Dx. 41.* Claimant's FEV1 was 3.19, and his MVV was 73. Again, the FEV1 value was non-qualifying and the MVV was qualifying. Thus, this study does not support the invocation of the interim presumption.

Claimant underwent another pulmonary function test on April 18, 1984. Claimant was 63 years old and measured 71 inches in height. Dr. Smiddy reported the FEV1 value as 2.48 and the MVV value as 91. *Dx. 33.* Both the FEV1 and MVV values are qualifying. After a bronchodilator was administered, Claimant's FEV1 value was 3.16, and the MVV value was 90. The post-bronchodilator FEV1 value is non-qualifying. "The fact that the post-bronchodilator test values were not qualifying does not invalidate the pre-bronchodilator test as proper evidence for invoking the presumption under Section 727.203(a)(2)." *Strako v. Zeigler Coal Co.,* 3 B.L.R. 1-136, 1-143 (1981). Thus, the pre-bronchodilator test supports the invocation of the presumption at 20 C.F.R. § 727.203(a)(2), and the post-bronchodilator test does not.

Dr. Abernathy administered a pulmonary function test to Claimant on July 16, 1984. *Dx. 32.* Claimant was 63 years old at the time of the study and measured 71 inches in height. The best effort of three trials yielded a FEV1 value of 2.6 and a MVV value of 67. These values are qualifying. After a bronchodilator was administered, the FEV1 value was 3.32. The MVV value was 81. These values are non-qualifying. Again, the pre-bronchodilator test supports the invocation of the interim presumption, and the post-bronchodilator test does not.

On January 18, 1991, Claimant underwent another ventilatory study. Dr. Forehand noted Claimant was 69 years old at the time of the test and measured 70 inches in height. *Dx. 81.* The pre-bronchodilator values are qualifying with a FEV1 of 2.47 and a MVV of 78. The post-bronchodilator values, however, are non-qualifying. Hence, the pre-bronchodilator study supports the invocation of the presumption that Claimant is entitled to benefits, and the post-bronchodilator study does not. These studies, however, are insufficient to invoke the §

727.203(a) presumption because the record only contains a single tracing. The quality standards require three tracings. 20 C.F.R. §§ 410.430 and 727.206(a). Therefore, the data from the January 18, 1991 pulmonary function test does not support the invocation of the interim presumption.

Dr. Forehand administered a second pulmonary function test on July 21, 1992. *Dx. 81.* Dr. Michos found the study unacceptable because of the lack of tracings. *Dx. 82.* There are no tracings of this study in the record. Therefore, this study does not comply with the quality standards, and it does not support the invocation of the interim presumption. 20 C.F.R. §727.206(a). Similar to prior studies, the July 21, 1992 study revealed qualifying pre-bronchodilator values and non-qualifying post-bronchodilator values.[9]

On January 31, 1994, Dr. Sargent conducted a pulmonary function study. *Dx. 116.* Claimant was 73 years old and measured 70 inches in height. The pre-bronchodilator values are qualifying with a FEV1 value of 2.42 and a MVV value of 75. There are no tracings of the FEV1 study; thus, this study is not sufficient to invoke the interim presumption. 20 C.F.R. §§ 410.430 and 727.206(a). Post-bronchodilator, the FEV1 value was 2.75. There is no post-bronchodilator MVV value listed, which precludes this study from establishing the presence of a chronic respiratory or pulmonary disease under § 727.203(a)(2). Thus, the January 31, 1994 study does not support the invocation of the interim presumption.

The last pulmonary function study of record was performed on February 8, 2001 by Dr. Forehand. *Dx. 151.* Claimant was 80 years old at the time of the study and measured 69 inches in height. The pre-bronchodilator study revealed a FEV1 value of 2.53 and a MVV value of 112. These are non-qualifying values. The post-bronchodilator study does not list a MVV value, which precludes this study from establishing the presence of a chronic respiratory or pulmonary disease under § 727.203(a)(2). Dr. George Zaldivar reviewed the study and found it to be unacceptable and recommended that it be repeated. *Ex. 6.* Regardless of Dr. Zaldivar's opinion, the February 8, 2001 study does not support the invocation of the interim presumption as none of the values are qualifying.

Considering the pulmonary function test evidence as a whole, Claimant has not sustained his burden of establishing by a preponderance of the evidence the presence of a chronic respiratory or pulmonary disease. Only two studies that comply with the quality standards reveal qualifying values: the pre-bronchodilator studies of April 18, 1984 and July 16, 1984. *Dx. 33 and 32.* These studies along with the three others that measured post-bronchodilator values all demonstrated that Claimant's improvement to non-qualifying values with bronchodilators. Pneumoconiosis is an irreversible process, and the objective pulmonary function data demonstrates that Claimant's condition was in fact reversible to a degree with bronchodilators. Thus, Claimant has not established the presence of a chronic respiratory or pulmonary disease and has not invoked the interim presumption at § 727.203(a)(2).

[9] The pre-bronchodilator FEV1 value was 2.43 and the MVV was 68. The post-bronchodilator FEV1 value was 2.55 and the MVV was 37. Claimant was 71 years old at the time of the study and measured 69 inches in height.

Arterial Blood Gas Studies

Claimant may also invoke the interim presumption with arterial blood gas (ABG) study evidence. The table at 20 C.F.R. § 727.203(a)(3) provides benchmarks against which to measure the ABG evidence of record. There are eight ABG studies in the record. Three of the studies also report values upon exercise. The following ABG studies are in the record:

EXHIBIT NO.	PHYSICIAN	DATE	PCO2	PO2
Dx. 16	Realica	4/28/80	31	82
			*33	*90
Dx. 41	Scott	9/30/82	35	76
Dx. 33	Smiddy	4/18/84	37	71
Dx. 32	Abernathy	7/16/84	35	70
			*35	*73
Dx. 81	Forehand	7/21/92	30	66
			*31	*66
Dx. 116	Sargent	1/31/94	33	84
Dx. 161	Forehand	5/8/97	32	79
Dx. 151	Forehand	2/8/01	38	86

*Indicates values upon exercise

Only the July 21, 1992 study reveals qualifying values. Both the at rest and upon exercise values of this study are qualifying.

Claimant bears the burden of establishing the presence of an impairment in the transfer of oxygen from the lung alveoli to the blood by a preponderance of the evidence. The single qualifying ABG does not sustain Claimant's burden in light of the other seven tests of record. Thus, Claimant has not invoked the interim presumption through §727.203(a)(3).

Medical Opinion Evidence

The Claimant can also invoke the interim presumption with medical opinion evidence. Section 727.203(a)(4) provides for the invocation of the interim presumption if the documented opinion of a physician exercising reasoned medical judgment establishes the presence of a totally disabling respiratory or pulmonary impairment. The preponderance of the medical opinion evidence does not support invocation of the interim presumption in this claim.

On November 21, 1979, Claimant was examined by an unknown individual.[10] The examiner noted that Claimant suffered from dyspnea, pain, or discomfort after exercise due to mild pneumoconiosis. *Dx. 14.* In a questionnaire presumably completed in conjunction with the November 21, 1979 examination, Claimant disclosed that he suffered from high blood pressure and was on blood pressure medication. Both the examination report and the questionnaire fail to offer any reasoning for the conclusions and answers given: boxes indicating yes or no are

[10] The report in the record is a copy of the original report, and the examiner's name is just beyond the bottom of the copy in the record. The signature of the examiner is illegible.

marked, but there is no background information supporting the markings. Furthermore, there is no indication that Claimant's dyspnea, pain, or discomfort after exercise was totally disabling. Thus, the report of the November 21, 1979 examination does not support the invocation of the interim presumption.

Dr. Dino examined Claimant on April 28, 1980. *Dx. 15.* Dr. Dino noted Claimant had diminished tolerance for walking, climbing stairs, lifting weight, and carrying a weight over distance. This diminished tolerance had been present for approximately a year and half at the time of the examination. Dr. Dino did not expound on his observation to discuss whether the diminished tolerance rose to the level of a totally disabling respiratory or pulmonary impairment. In fact, Dr. Dino did not state a cause, pulmonary or otherwise, of Claimant's diminished tolerance. As Dr. Dino did not remark on Claimant's respiratory or pulmonary impairment, his medical opinion does not support the invocation of the interim presumption.

Dr. H.C. Scott examined Claimant on September 30, 1982 in conjunction with Claimant's claim for state black lung benefits. *Dx. 41.* Dr. Scott noted that a pulmonary function study revealed a normal FEV1 and a slightly reduced MVV. There is no indication to which pulmonary function study Dr. Scott is referring or what the actual FEV1 and MVV values were. Dr. Scott noted slightly diminished breath sounds. He diagnosed Meniere's Syndrome and diabetes mellitus. Dr. Scott did not discuss whether Claimant suffered from a totally disabling pulmonary or respiratory impairment. Thus, his report does not support the invocation of the interim presumption.

Dr. Joseph Smiddy examined Claimant on April 18, 1984. *Dx. 33 (repeated at Dx. 43).* Claimant told Dr. Smiddy that he frequently suffered from shortness of breath and had to sleep sitting up in a chair to breathe. Claimant also stated that he could only walk 30 feet on level ground before having to stop and rest. In Dr. Smiddy's opinion, Claimant

> certainly has a significant degree of respiratory impairment as demonstrated in his PFT's [dated April 18, 1984] and combining all the objective evidence with his hypoxemia of 70.5, and considering that along with this patient's total situation, it would be my opinion that he is not capable of completing the type of physical activity required for coal mine employment. He is therefore in my opinion 100% totally and permanently disabled for coal mine employment.

Dx. 33. Dr. Smiddy did not opine that Claimant suffered from a totally disabling respiratory or pulmonary disease. In fact, Dr. Smiddy's conclusion that Claimant is totally disabled from coal mine employment was based on Claimant's "total situation." In his report, Dr. Smiddy noted that Claimant suffered from severe pain in the left knee and was very obese. Claimant also complained of frequent headaches, dizziness, sinus trouble, difficulty swallowing, indigestion, joint aches, swelling of the feet or ankles and backaches. Being disabled based on his total situation does not equate to Claimant being totally disabled as a result of a respiratory or pulmonary disease. Therefore, Dr. Smiddy's report does not support the invocation of the interim presumption.

Dr. Robert Abernathy examined Claimant on July 16, 1984, and authored a medical report dated July 18, 1984. *Dx. 32.* Dr. Abernathy also reviewed some of Claimant's medical records. In the course of his examination and review of medical records, Dr. Abernathy noted several medical problems including high blood pressure, diabetes, dizziness due to a cracked eardrum Claimant suffered during World War II, swelling and pain in the left knee, and hiatal hernia. Dr. Abernathy conducted a pulmonary function study which revealed "the presence of some obstructive component to airflow with reversible bronchospasm revealing a normal vital capacity." In conclusion, Dr. Abernathy opined that Claimant "does appear to have some medical problems but so far as his lungs are concerned, they appear to be free of coal worker's pneumoconiosis. The studies that were done indicate that he should be able to return to his usual occupation in the mines so far as his lungs are concerned." As Claimant's post-bronchodilator pulmonary function test values were not qualifying under 20 C.F.R. § 727.203(a)(2), it is rational to conclude that Claimant's lung impairment would not prevent him from returning to work in the coal mines. Therefore, Dr. Abernathy's report does not support the invocation of the interim presumption.

Dr. George Kress reviewed medical records and medical opinions of other physicians and authored a report dated July 1, 1986. *Dx. 42.* Dr. Kress also noted that Claimant suffered from many significant medical problems that were unrelated to his respiratory system. Dr. Kress specifically noted Claimant's obesity, Meniere's Syndrome, hypertension, and hiatus hernia. From a total man standpoint, Dr. Kress opined that Claimant is unable to return to coal mine work. From a pulmonary standpoint, however, Claimant would be able to return to his coal mine work. In Dr. Kress's opinion, Claimant "has demonstrated evidence of a very mild degree of obstructive impairment which is largely reversible with a bronchodilator." This evidence combined with Claimant's complaint of productive cough and wheezing lead Dr. Kress to diagnose chronic bronchitis with an element of bronchospasm. Thus, Dr. Kress's opinion is much like that of Drs. Smiddy and Abernathy in that the physicians note Claimant suffered from multiple medical problems that taken together would lead to the conclusion that Claimant was unable to return to his coal mine employment, but Claimant's respiratory and pulmonary health alone would not have prevented Claimant from working in the coal mines. Hence, Dr. Kress's opinion does not support the invocation of the interim presumption.

Dr. Randolph Forehand examined Claimant on January 18, 1991. *Dx. 81.* Claimant informed Dr. Forehand that he had been suffering from shortness of breath since 1976. As part of the examination, Dr. Forehand took a chest x-ray and performed a pulmonary function test. Dr. Forehand concluded that Claimant suffered from "exertional dyspnea secondary to moderately severe chronic obstructive pulmonary disease (COPD). His degree of shortness of breath restricts his activities and would limit him to a sedentary job if he were seeking employment." Thus, Claimant is unable to return to his coal mine job as a section foreman, which required him to be on his feet for eight hours a day and walk at least 450 feet. *Dx. 45 (Tr. at 17 and 18).* Hence, in Dr. Forehand's opinion, Claimant suffered from a totally disabling respiratory or pulmonary impairment. Dr. Forehand's January 18, 1991 opinion supports the invocation of the interim presumption.

In response to additional pulmonary function and arterial blood gas testing, Dr. Forehand authored a brief report on July 21, 1992. *Dx. 81.* Dr. Forehand stated that there had been no

significant change in Claimant's pulmonary function since January 1991. Claimant's blood gas study led Dr. Forehand to conclude that he suffered from "a pulmonary impairment of a gas exchange nature." Dr. Forehand did not discuss the degree of this pulmonary impairment. It is unclear from the July 21, 1992 report whether Dr. Forehand's statement that there had been no significant change in Claimant's pulmonary function since his January 18, 1991 report equates to Dr. Forehand again concluding that Claimant suffered from a totally disabling respiratory or pulmonary impairment. In the 1992 report, when Dr. Forehand mentioned Claimant's pulmonary impairment, he did not state whether this impairment was the same as Claimant's shortness of breath discussed in the 1991 report. Thus, as Dr. Forehand did not discuss the degree of impairment in his 1992 report, it does not support the invocation of the interim presumption.

On June 28, 1993, Dr. John Michos authored a brief report based on the July 21, 1992 chest x-ray and pulmonary function test. *Dx. 86.* Dr. Michos did not opine on whether Claimant's complaints of shortness of breath rose to the level of a totally disabling pulmonary impairment. Dr. Michos opined that Claimant's arterial blood gas study results and complaints of dyspnea with exertion are secondary to significant obesity with deconditioning. Since Dr. Michos did not discuss the degree of Claimant's impairment, his report does not support the invocation of the interim presumption.

On July 27, 1993, Dr. Forehand responded to Dr. Michos's opinion that Claimant's obesity was the cause of his dyspnea. Dr. Forehand disagreed with Dr. Michos and reiterated that he felt that "hypoxemia both at rest and with exercise is due to pulmonary impairment of a gas exchange nature and not from atelectasis or hypoventilation from obesity." *Dx. 102.* Dr. Forehand's July 27, 1993 report concerned the etiology of Claimant's impairment, not the degree. Therefore, this report does not support the invocation of the interim presumption.

Dr. Dale Sargent examined Claimant on January 31, 1994, and authored a medical report dated February 1, 1994. *Dx. 116.* As part of the examination, a chest x-ray was taken and pulmonary function and arterial blood gas studies were administered. Dr. Sargent noted Claimant's reported history of episodic wheezing. In conclusion, Dr. Sargent found

> with respect to his ventilatory status alone, the ventilatory abnormalities are really very mild and would not preclude him from doing any work required in the mining of coal that a normal 73 year old man could be expected to do. Specifically, he has the respiratory capacity to perform his last job as a foreman, as he describes that job to me.

Dx. 116. Thus, in Dr. Sargent's opinion, Claimant was able to "walk through the mines pretty much during a whole shift supervising men and doing tests on the atmosphere for gas and dust levels." The pulmonary function test administered by Dr. Sargent revealed qualifying values under 20 C.F.R. § 727.203(a)(2). Dr. Sargent, however, describes Claimant's ventilatory abnormalities as "very mild" based on the same values. While Dr. Sargent may consider these values as revealing a "very mild" impairment, the regulations do not. 20 C.F.R. § 727.203(a)(2). Thus, Dr. Sargent's opinion is given little weight because it conflicts with the regulations.

Dr. Sargent's deposition testimony was taken on May 12, 1994. *Dx. 116.* In the course of his testimony, Dr. Sargent largely repeated the conclusions he reached in his medical report. He did not explain why he classified Claimant's ventilatory abnormalities as "very mild" when the pulmonary function test values are qualifying under 20 C.F.R. § 727.203(a)(2). Dr. Sargent did state that he does not rely on the MVV value in determining the presence of a respiratory impairment. *Dx. 166 at 19.* The regulations applicable to this claim, however, do rely on the MVV value. 20 C.F.R. § 727.203(a)(2). As Dr. Sargent's views are contrary to the regulations applicable to this claim, his report and deposition testimony are given little weight.

After reviewing medical records and physicians' reports, Dr. Dahhan authored a report on March 30, 1994. *Dx. 114.* Upon review of these records and reports, Dr. Dahhan concluded that "from a respiratory standpoint, Mr. Johnson, has no disability and he retains the respiratory capacity to continue his previous coal mining work or job of comparable physical demand based on the clinical, radiological and physiological data generated from various exams." Dr. Dahhan did not provide further explanation for his conclusion. He did not indicate which exams supported his conclusion or how he reached his conclusion. As Dr. Dahhan gave no explanation beyond the basic statement that the medical data he reviewed lead him to reach a conclusion, his opinion is not well-documented or well-reasoned and will be given little weight. Despite the lack of rationale, Dr. Dahhan's report does not support the invocation of the interim presumption.

Dr. Gregory Fino reviewed the medical reports of record and authored his own medical report on April 21, 1994. *Dx. 114.* Throughout his review of the various medical reports, he noted that the testing data revealed "a totally reversible obstructive abnormality without any evidence of significant respiratory impairment." Dr. Fino cited to Claimant's post-bronchodilator pulmonary function test values as support for his statement. Overall, Dr. Fino classified Claimant's respiratory impairment as mild but not disabling. "From a respiratory standpoint, this man is neither partially nor totally disabled from returning to his last mining job or a job requiring similar effort." The preponderance of pulmonary function and arterial blood gas study evidence supports Dr. Fino's opinion. Dr. Fino's deposition testimony was taken on May 12, 1994, and it echoes his medical report. *Dx. 117.* Dr. Fino's opinion does not support the invocation of the interim presumption.

On February 8, 2001, Dr. Forehand saw Claimant during an office visit. *Dx. 151.* In his Progress Record, Dr. Forehand noted Claimant's shortness of breath upon exertion and his use of a nebulizer four times a day. He also noted Claimant's other medical problems such as colon cancer and diabetes. Dr. Forehand did not comment on whether Claimant suffered from a totally disabling respiratory or pulmonary disease. Thus, the February 8, 2001 Progress Record does not support the invocation of the interim presumption.

Dr. Fino reviewed the evidence of record submitted after his April 21, 1994 report and authored a supplemental report dated July 2, 2001. *Dx. 158.* The newly submitted evidence did not cause Dr. Fino to change any of his opinions as summarized in his 1994 report. Thus, Dr. Fino's supplemental report does not support the invocation of the interim presumption.

Dr. Kirk Hippensteel reviewed the medical reports of record and authored his own medical report on March 28, 2002. *Dx. 174.* Dr. Hippensteel noted the variety of medical problems discussed by other physicians of record. Dr. Hippensteel discussed Claimant's pulmonary health:

> I do not think his last pulmonary function test while he is suffering from many nonpulmonary diseases, is accurately reflective of his true lung function, but this man has had no more than very mild impairment in lung function post bronchodilator, with significant reversibility in function from his medication, which is neither consistent with coal workers' pneumoconiosis or indicative of enough pulmonary impairment to keep him from a pulmonary standpoint, from going back to his previous job in the mines.

Dx. 174. Thus, Dr. Hippensteel concurs with Drs. Fino, Kress, Abernathy, and Smiddy in concluding that Claimant suffered from various medical ailments, but Claimant's pulmonary condition did not preclude him from returning to the mines. Dr. Hippensteel's deposition testimony of February 16, 2004 echoes the conclusions of his medical report. *Ex. 5.* Dr. Hippensteel's report does not support the invocation of the interim presumption.

Dr. James Castle reviewed the medical evidence of record and authored his own medical report on January 29, 2004. *Ex. 2.* Dr. Castle concluded that Claimant was totally disabled from a whole man standpoint; that is, Claimant's "advanced age, history of colon cancer, hypertensive cardiovascular disease with cardiomyopathy, possible ischemic heart disease, valvular heart disease, insulin dependent diabetes mellitus, and other nonpulmonary medical problems such as gout" caused Claimant's total disability. In regards to Claimant's pulmonary health, Dr. Castle noted the Claimant had a mild impairment with significant reversibility with bronchodilators. Thus, Dr. Castle joins Drs. Hippensteel, Fino, Kress, Abernathy, and Smiddy in concluding that Claimant's overall health problems left him totally disabled but his pulmonary impairment was not totally disabling. Dr. Castle's deposition testimony taken on February 9, 2004 echoes the conclusions reached in his medical report. *Ex. 4.* Neither Dr. Castle's medical report or his testimony support the invocation of the interim presumption.

After reviewing various reports and objective tests of record, Dr. Dahhan authored a report on February 3, 2004. *Ex. 3.* In conclusion, Dr. Dahhan stated that Claimant "demonstrated an intermittent mild obstructive ventilatory defect that was not sufficient to be disabling and was consistent with bronchial asthma with no evidence of total or permanent pulmonary disability." Dr. Dahhan also noted Claimant's various other medical problems that "render[ed] him unable to be engaged in gainful employment prior to his death." In Dr. Dahhan's opinion, Claimant was not totally disabled from a pulmonary standpoint. Dr. Dahhan's report does not support the invocation of the interim presumption.

The preponderance of the medical opinion evidence does not support the invocation of the interim presumption. 20 C.F.R. § 727.203(a)(4). Dr. Forehand was the sole physician to find Claimant totally disabled from a pulmonary standpoint. Several other doctors noted Claimant's various medical ailments that left him totally disabled from a whole man standpoint, but Claimant's pulmonary condition was not totally disabling. The preponderance of the medical

opinion evidence is supported by the preponderance of the objective testing evidence: Claimant's pulmonary function studies demonstrated that he suffered from a pulmonary impairment that improved with bronchodilators. Thus, Claimant is not totally disabled from a pulmonary standpoint. Claimant has not sustained the necessary burden in order to invoke the interim presumption.

Discussion of the § 727.203(a) Interim Presumption

The preponderance of the various types of evidence does not invoke the § 727.203(a) interim presumption. Rebuttal of the interim presumption is not necessary. The claim now must be considered under the regulations at 20 C.F.R. Part 410 Subpart D. *Muncy v. Wolfe Creek Collieries Coal Co., Inc.,* 3 B.L.R. 1-627, 1-634 (1981).

Part 410

Benefits are provided "to coal miners who are totally disabled due to pneumoconiosis arising out of employment in one or more of the Nation's coal mines." 20 C.F.R. §410.410(a). To establish entitlement to benefits, a claimant must establish by a preponderance of the evidence, that he: (1) suffers from pneumoconiosis; (2) that such pneumoconiosis arose out of coal mine employment; (3) that the miner is totally disabled; and (4) that such total disability is due to pneumoconiosis. 20 C.F.R. § 410.410(b). Failure to establish any one of these elements will result in a denial of benefits. *Hall v. Director, OWCP,* 2 B.L.R. 1-998 (1980).

The Existence of Pneumoconiosis

A finding of pneumoconiosis may be made through any of the following methods: (1) chest x-ray evidence; (2) autopsy or biopsy[11]; (3) by operation of a presumption; or (4) by "other relevant evidence." 20 C.F.R. § § 410.414(a)–(c). The regulations at § 410.401(b) define "pneumoconiosis" as follows:

> (1) a chronic dust disease of the lung arising out of coal mine employment in the Nation's coal mines, and includes coal workers' pneumoconiosis, anthrcosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotubercolosis, arising out of such employment; or (2) any other chronic respiratory or pulmonary impairment when the conditions are met for the application of the presumption described in § 410.414(b).

20 C.F.R. § § 410.401(b)(1) and (b)(2).

X-ray Evidence

The chest x-ray evidence of record is detailed in Appendix A. The analysis to determine the presence of pneumoconiosis is the same as determining whether Claimant had invoked the interim presumption at 20 C.F.R. § 727.203(a)(1). The preponderance of the chest x-ray

[11] There is no autopsy or biopsy evidence in the record.

evidence does not establish the presence of pneumoconiosis. As discussed above, only the February 21, 1983 x-ray establishes the presence of pneumoconiosis. A single positive x-ray does not sustain Claimant's burden of establishing the pneumoconiosis by a preponderance of the evidence.

Presumptions

Where the existence of pneumoconiosis is not established through a chest x-ray, biopsy, or autopsy under § 410.414(a), but other evidence demonstrates the existence of a totally disabling chronic respiratory or pulmonary impairment, it may be presumed, in the absence of evidence to the contrary, that a miner is totally disabled due to pneumoconiosis. 20 C.F.R. § 410.414(b)(1). This presumption applies where a miner was employed for 15 or more years in one or more of the Nation's underground coal mines. 20 C.F.R. § 410.414(b)(3). Claimant has established over 15 years of underground coal mine employment.[12] Claimant, however, has not demonstrated the existence of a totally disabling chronic respiratory or pulmonary impairment. Claimant's pulmonary function tests and blood gas studies yield no qualifying values.[13] 20 C.F.R. § 410.426(b) and Appendix to Subpart D of Part 410. Thus, Claimant is not entitled to the presumption that he was totally disabled due to pneumoconiosis.

Other Relevant Evidence

Even though the existence of pneumoconiosis is not established under § 410.414(a) by x-ray or under § 410.414(b) by evidence demonstrating a totally disabling chronic respiratory impairment, a finding of totally disability due to pneumoconiosis may be made if "other relevant evidence" established (1) the existence of a totally disabling chronic respiratory or pulmonary impairment, and (2) that such impairment arose out of employment in a coal mine. 20 C.F.R. § 410.414(c). As discussed above, the preponderance of the evidence establishes that Claimant did not suffer from a totally disabling chronic respiratory or pulmonary impairment. The pulmonary function, arterial blood gas, and medical opinion evidence each fail to establish the presence of a totally disabling chronic respiratory or pulmonary impairment. A majority of physicians agreed that Claimant was totally disabled from a whole man standpoint, but not from a pulmonary standpoint. Thus, Claimant has not established the presence of pneumoconiosis or that he was totally disabled due to pneumoconiosis.

Conclusion

Claimant is not entitled to benefits. Over the twenty-five year history of this claim, other administrative law judges have reached the same conclusion. There was no error of law or fact in the prior determination, and Claimant's request for modification is denied.

---

[12] At the hearing held on August 31, 2004, the parties stipulated to at least 42 years of coal mine employment. Descriptions of Claimant's various jobs throughout the record indicate that at least 15 years of that time was spent underground. *Dx. 3, 4, and 5.*

[13] The testing data is discussed above. While the qualifying values for 20 C.F.R. § 727.203(a) and 20 C.F.R. Part 410 are different, the preponderance of Claimant's testing data is not qualifying under either provision. In fact, none of Claimant's pulmonary function test and arterial blood gas study values are qualifying under Part 410.

ORDER

IT IS ORDERED that the claim for benefits filed by Mary Johnson on behalf of John Johnson is DENIED.

A

Thomas M. Burke
Associate Chief Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. §725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601. A copy of this Notice of Appeal must also be served on Donald S. Shire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210.

APPENDIX A

Dx. 17: 4/28/80: Eryilmaz, Nurettin (B/BCR)
Film is completely negative.

Dx. 18: 4/28/80: Smith, Charles (B/BCR)
Reread: Film quality unreadable

Dx. 21 (repeated at Dx. 41): 4/28/80: Eryilmaz, Nurettin (B/BCR)
UICC Category 0, no pneumoconiosis, calcified granulomas on the left, old pleuritis in the region of the left costo-phrenic sinus

---

Dx. 41: 2/20/81: Evans, William (No qualifications noted)
PA and lateral films of the chest demonstrate a normal cardiac silhouette for this size individual. There is slight tortousity of the aortic knob. The left hilar area is prominent but appears to be vascular in nature. Old calcification is noted in the left apex and the left parahilar region consistent with old granulomatous disease. No evidence to indicate pneumoconiosis is noted.

Dx. 41: 9/21/82: Anziulewicz, John (No qualifications noted)
Both lungs are fully expanded and free of pneumoconiosis, tuberculosis, tumor and inflammatory disease process. ILO-1980- 0/0. The heart, bones, and soft tissues are normal.

Dx. 41: 9/30/82: Scott, H.C. (No qualifications noted)
Negative for acute abnormality.

Dx. 22: 2/21/83: Brandon, B. (B)

1. Mild uncoiling of the thoracic aorta.
2. Hilar lymph node calcification in the left with left apical calcified pulmonary parenchymal nodule consistent with residual old granulomatous disease.
3. Nodular densities involving the right upper, right middle, left upper, and left middle lung zones. These would be consistent radiographically with pneumoconiosis and as such would be classified by direct comparison with ILO standard radiograph as a q/q, 2/1 profusion.

Dx. 31: 2/21/83: Bassali, Maurice (B/ BCR)
Pneumoconiosis category q/t, 2/2 in all six lung zones.

Dx. 34: 2/21/83: Wiot, Jerome F. (B/ BCR)
This film was taken in expiration and is not of acceptable quality.

Dx. 35: 2/21/83: Spitz, Harold (B/BCR)

Film quality is unreadable.

Dx. 36: 2/21/83: Felson, Benjamin (BCR)
PA film of the chest is of poor quality. There is no evidence of pneumoconiosis or other significant abnormality.

Dx. 38: 2/21/83: Schmidt, William (B)
Film is of grade II quality. I cannot see clearly out to the rib cage margins. Costophrenic sulci are rounded and deep. Diaphragms are rounded. Heart shows left ventricular preponderance not enlarged with uncoiled aorta. Patient has taken only a 6 ½ lung inspiration. Trachea is midline. Hilar calcifications bilaterally. B vascular markings are prominent. In both lower lung zones are areas of rounded nodulation 1/0 q. 1980 ILO Classification. Heart borders are clear. There are no pleural, pericardial, or diaphragmatic calcifications. There are no pleural plaques. No large opacities.

Dx. 39: 2/21/83: Ramakrishnan, M.R. (No qualifications noted)
Film quality II.
IMPRESSION: Pneumoconiosis of the category p, 1/1 is noted involving both lungs. Slightly enlarged and calcified lymph nodes are noted in the hila.

Dx. 43: 2/21/83: Williams, Cordell (No qualifications noted)
Thoracic cage is normal. There is elongation and toruosity of the aorta, left ventricular configurations of the heart. Heart is of normal size. Four lower zones, there is increase in nodular and irregular fibrosis compatible with 1/1 p/p pneumoconiosis; arteriosclerotic aorta.

Dx. 43: 2/21/83: Fisher, Steven (B/BCR)
Pneumoconiosis category p/p, 2/1 in all six zones.

Dx. 43: 2/21/83: Penman, Robert (No qualifications noted)
PA view of the chest from Grundy Hospital. This is of good quality. It shows fine nodulation in all regions of the lungs partly obscuring the blood vessel pattern consistent with pneumoconiosis stage II (Cincinnati, 2/2 p).

Dx. 23: 9/9/83: Milner, Lee (BCR)
There is a slight increase in interstitial markings bilaterally. There are minimal pleural changes along the lateral thoracic walls. The cardiovascular silhouette is normal. Hilar calcifications are evident as well as a calcification in the left apex.
IMPRESSION: Mild to moderate interstitial lung disease and old granulomatous disease.

Dx. 20: 9/9/83 Milner, Lee (BCR)
Pneumoconiosis category t/t, 1/1 in mid and lower zones.
Bilateral hilar calcification / calcified granuloma left upper lobe.

Dx. 19: 9/9/83 Gaziano, D. (B)
No parenchymal abnormalities consistent with pneumoconiosis.

Dx. 33: 4/18/84: Westerfield, Larry (No qualifications noted)
No parenchymal abnormalities consistent with pneumoconiosis.

1) Hilar granulomatous calcifications
2) Few old linear scars – lingula (illegible) segment

Dx. 42: 4/18/84: Kress, George (B)
No parenchymal abnormalities consistent with pneumoconiosis.

Dx. 32: 7/16/84: Cunnigham, Dorris (B)
Category 0/1, p/p, both lower zones.

Dx. 34: 7/16/84: Wiot, Jerome F. (B/ BCR)
Film is completely negative. There is an old calcified granuloma at the left apex with calcified lymph nodes in the left hilum consistent with old histoplasmosis or tuberculosis.

Dx. 35: 7/16/84: Spitz, Harold (B/BCR)
The bones, soft tissues, heart and aorta are within normal limits. There are some scattered hilar and pulmonary calcifications. There is a density posterior to the left side of the heart, just adjacent to the spine. The lungs are otherwise clear and there is no pleural disease. The lateral view shows a lobulated nodular density overlying the upper ascending aorta which may contain calcification.

IMPRESSION: No evidence of pneumoconiosis. Density posterior to the left side of the heart could represent a hiatus hernia or some mass. Nodular density seen on lateral view overlying the upper ascending aorta, possibly containing calcium but this is not definite. Scattered hilar and pulmonary calcifications.

It is recommended further work-up of the mass posterior to the left side of the heart and the nodular density overlying the upper ascending aorta be performed.

Dx. 36: 7/16/84: Felson, Benjamin (BCR)
PA and lateral films of the chest are of fairly good quality. There is no evidence of pneumoconiosis or other significant abnormality.

Dx. 37: 7/16/84: Scott, John (B); Anderson, C.L. (B); Fiehler, Paul
The right diaphragm is lobulated, but the remaining portions of the diaphragms are not remarkable. The cardiac silhouette is normal. There is slight dilation of the ascending thoracic aorta. Calcified hilar nodes are noted on the left and a calcified granuloma is seen in the left apex. The lung fields are otherwise clear and the pleural surfaces are not remarkable. The horizontal fissure can be seen on the right. There is no evidence of pneumoconiosis (0/0).

Dx. 42: 7/16/84: Kress, George (B)
Film is completely negative.

Dx. 107: 3/7/90: Shipley, Ralph (B/BCR)
No parenchymal abnormailities consistent with pneumoconiosis. Calcified granuloma left apex. No CWP.

Dx. 107: 3/7/90: Spitz, Harold (B/BCR)
Film is completely negative. Tortuous aorta.

Dx. 114: 3/7/90: Wiot, Jerome F. (B/BCR)
Film is completely negative.

Dx. 117: 3/7/90: Fino, Gregory (B)
No parenchymal abnormalities consistent with pneumoconiosis.

Dx. 81: 7/21/92: Bassali, Maurice (B/BCR)
There is chronic diffuse interstitial lung disease consistent with pneumoconiosis q/t with profusion of 1/2 in all six lung zones. There are bilateral wall pleural plaques, Width A, Extent 3.

Dx. 81: 7/21/92: Shahan, Michael (No qualifications noted)
Mild interstitial disease, probably chronic. Old granulomatous disease.

Dx. 84: 7/21/92: Greene, R. (B/BCR)
No parenchymal abnormalities consistent with pneumoconiosis.

Dx. 85: 7/21/92: Navani, S. (B/BCR)
Film is completely negative.

Dx. 117: 7/21/92: Fino, Gregory (B)
No parenchymal abnormalities consistent with pneumoconiosis.

Dx. 118: 7/12/93: Spitz, Harold (B)
No parenchymal abnormalities consistent with pneumoconiosis.

Dx. 118: 7/12/93: Wiot, Jerome (B/BCR)
Film is completely negative.

Ex. 7: 1/3/94: Meyer, Christopher (B/ BCR)
No parenchymal abnormalities consistent with pneumoconiosis.

Ex. 7: 1/3/94: Spitz, Harold (B/BCR)
No parenchymal abnormalities consistent with pneumoconiosis.

Dx. 114: 1/31/94: Scott, William F. (No qualifications noted)
No parenchymal abnormalities consistent with pneumoconiosis. Calcified granuloma left apex left hilum compatible with healed TB or histoplasmosis. Hyperinflation lungs due to emphysema or deep breath.

Dx. 114: 1/31/94: Wheeler, Paul S. (No qualifications noted)
No parenchymal abnormalities consistent with pneumoconiosis. Normal except for tiny calcified granuloma left apex and small ones in left hilum compatible with healed TB or histoplasmosis, minimal arteriosclerosis aortic arch and descending thoracic aorta, kyphosis and degenerative arthritis lower thoracic spine and minimal obesity. No evidence of silicosis or CWP.

Dx. 114: 1/31/94: Eisner, David (No qualifications noted)
No parenchymal abnormalities consistent with pneumoconiosis. Left hilar granulomas and a left apical granuloma. Calcification of aorta.

Dx. 114: 1/31/94: Kim, Young (B/BCR)
No parenchymal abnormalities consistent with pneumoconiosis. Several calcified granulomata in the hilar (illegible) and left upper lobe.

Dx. 114: 1/31/94: Wiot (B/BCR)
Film is completely negative.

Dx. 116: 1/31/94: Sargent (B)
No parenchymal abnormalities consistent with pneumoconiosis.

Dx. 118: 1/31/94: Bassali, Maurice (B/BCR)
Pneumoconiosis category p/t, 1/2 in all six lung zones.

Dx. 161: 2/15/95: Shahan, Michael (No qualifications noted)
PA and lateral views demonstrate mild interstitial thickening in the bases, greater on the left. The left apex has a 5 x 8 mm. calcified granuloma. The AP window also has a calcified lymph node. The lower thoracic spine has mild degenerative change. The heart size is normal. The chest remains unchanged from July 21, 1992.
Impression: No significant abnormality or change.

Dx. 161: 2/4/00: CT SCAN: Nicholas, Radoslav
There are a few scattered granulomata and there are calcified mediastinal lymph nodes. There is no indication of mediastinal or axillary lymphadenopathy. No masses are evident. Lung fields revealed no infiltrations or consolidations.

Dx. 174: 2/4/00: CT SCAN: Hippensteel, Kirk
There appears to be slight haziness from movement on some slices, but no rounded opacities suggestive of pneumoconiosis are seen. There appears to calcification in lymph nodes in

aortopulmonary area of left hilum and also in right paratracheal area. There is also calcification in aortic valve.

Dx. 176: 2/4/00: CT SCAN: Fino, Gregory
There were no pleural and no parenchymal abnormalities consistent with occupational pneumoconiosis.

Dx. 151: 2/8/01: Forehand, Randolph (B)
Pneumoconiosis category s/t, 1/0 in right mid and lower zones and the left lower zone.

Dx. 153: 2/8/01: Alexander, Michael (B/BCR)
Pneumoconiosis category q/t, ½ in all zones except the upper right zone.

Dx. 154: 2/8/01: Sargent, E. Nicholas (B/BCR)
No parenchymal abnormalities consistent with pneumoconiosis.

Dx. 158: 2/8/01: Scott, William (No qualifications noted)
No parenchymal abnormalities consistent with pneumoconiosis.

Dx. 160: 2/8/01: Kim, Young C. (B/BCR)
No parenchymal abnormalities consistent with pneumoconiosis.

Dx. 158: 2/8/01: Wheeler, Paul (No qualifications noted)
No parenchymal abnormalities consistent with pneumoconiosis.

Dx. 168: 2/8/01: Wiot, Jerome F. (B/BCR)
No parenchymal abnormalities consistent with pneumoconiosis.

Ex. 1: 2/8/01: Perme, Charles M. (B/BCR)
No radiographic findings consistent with coal workers' pneumoconiosis.
Bilateral pleural changes may represent pleural plaques from asbestos exposure, or may represent pleural fat.
Dense right hilum that may represent an enlarged pulmonary artery or possibly hilar lymphadenopathy. Comparison with old chest films is recommended to document stability. If no old films are available for comparison, chest CT scan is recommended for further evaluation.